Helping the Medicine Go Down: How a Spoonful of Mediation Can Alleviate the Problems of Medical Malpractice Litigation

SCOTT FOREHAND

I. INTRODUCTION

Traditionally, claims of medical malpractice have been resolved through tort-based litigation.[1] However, tort-based litigation has received much criticism as a method for resolving medical malpractice disputes. Critics point to a number of problems, including the high emotional and financial costs to the litigants, the detrimental effect on the doctor-patient relationship, and the inability of tort litigation to deter physician negligence. In response to these problems, states have instituted some ill-conceived reforms, including tort reform legislation and poorly-planned alternative dispute resolution (ADR) schemes. Some commentators have advocated abandoning the current system entirely in favor of new theories of recovery.

This Note argues that many of the problems of medical malpractice litigation can be alleviated through the simple use of mediation as a first step in the medical malpractice dispute process. This relatively innocuous reform could improve the access of injured patients to compensation, restore a sense of fairness to medical malpractice proceedings, and improve quality of care by encouraging open communication between doctors and patients. Additionally, a major overhaul of the current system would simply not be necessary. Part II of this Note reviews the current medical malpractice tort system and concludes, in agreement with the bulk of the literature, that the tort litigation system neither remedies injured patients nor effectively serves any useful public policy. Part III analyzes various attempts to address the problems of medical malpractice litigation and suggests that most of these attempts are ill conceived. Part IV describes the mediation process and the theoretical benefits of mediation in a medical malpractice dispute. Part V analyzes two empirical studies that strongly suggest that mediation can effectively resolve medical malpractice disputes. Finally, Part VI concludes that many of the problems with the current medical malpractice litigation

---

[1] Evidence of the medical malpractice tort case can be found as early as fourteenth-century England and late nineteenth-century America. *See* BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 308 (3d ed. 1997).

system could be alleviated with the simple use of mediation as a first step in the dispute resolution process.

II. THE CURRENT MEDICAL MALPRACTICE SYSTEM

A. *Criticism of the Current System*

Advocacy of a new system to resolve medical malpractice disputes necessarily assumes that the current system is flawed. An ideal medical malpractice dispute resolution system should provide compensation for patients injured through medical negligence, provide an incentive for doctors and hospitals to reduce medical negligence, preserve the doctor-patient relationship whenever possible, and optimize cost efficiency. However, the current tort-based litigation system for medical malpractice wholly fails to meet these standards.[2] For example, a recent study concluded that there are more than 180,000 deaths or serious injuries caused by the negligence of physicians and hospitals each year in the United States.[3] However, probably only one to ten percent of the patients involved in occurrences of negligence actually file malpractice lawsuits.[4] These statistics highlight one of the glaring failings of the current system—that injured patients simply are not compensated.

Contributing to the problem of medical malpractice litigation is the emergence of managed care. Patients in managed care systems are more likely to be dissatisfied with their health care than patients who use the traditional fee-for-service system.[5] Accordingly, patients in managed care plans are probably more likely to claim malpractice than patients who have the freedom to choose their doctors.

---

[2] *See, e.g.*, William M. Sage, *Enterprise Liability and the Emerging Managed Health Care System*, 60 LAW & CONTEMP. PROBS., Spring 1997, at 160.

[3] *See* PAUL C. WEILER, MEDICAL MALPRACTICE ON TRIAL 12 (1991).

[4] *See* PATRICIA DANZON, MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY 10 (1985); A. Russell Localio et al., *Relation Between Malpractice Claims and Adverse Events Due to Negligence: Results of the Harvard Medical Practice Study III*, 325 NEW ENG. J. MED. 245, 248 (1991).

[5] A recent study of over 10,000 patients revealed that patients who chose their doctors were up to 20% more likely to rate their health care as "very good" or "excellent" than patients who were assigned doctors. *See* Julie Schmittdiel et al., *Choice of a Personal Physician and Patient Satisfaction in a Health Maintenance Organization*, 278 JAMA 1596, 1596 (1997).

B. *Specific Problems with Litigating Medical Malpractice*

1. *Cost*

As a method for resolving disputes between doctors and patients, litigation presents a multitude of problems.[6] First, the cost of resolving a medical malpractice dispute, which may be measured in terms of transaction costs, parties' overall satisfaction with the resolution process, the effect on the doctor-patient relationship, and the finality of the resolution,[7] is very high in litigation. Transaction costs include attorneys' fees, time lost, and emotions spent.[8] Both doctors and patients suffer high transaction costs in medical malpractice litigation.[9]

Another factor that is relevant to the overall cost of resolving medical malpractice disputes is the satisfaction of the parties with the resolution process.[10] Parties are generally satisfied with a resolution process if they feel that it is fair. Fairness, in turn, depends on the opportunity a party has to express himself, the amount of participation a party has in shaping a settlement, and the ability a party has to control final decisions.[11] Litigation,

---

[6] Many of the problems to be discussed are endemic to litigation in general, but these problems are often exacerbated in the context of a medical malpractice dispute.

[7] *See* James W. Reeves, *ADR Relieves Pain of Health Care Disputes*, 49 DISP. RESOL. J., Sept. 1994, at 15.

[8] *See id.*

[9] Because medical malpractice lawsuits commonly last months, if not years, the financial burdens on the patient can be considerable. *See id.* at 16. Injured patients seldom have the financial resources to pursue an extended court battle in the first place, and even when they do, they will probably lose significant time at work. *See id.* at 15–16. With regard to emotions, a patient suffers through an extended examination of his personal health matters, and he lives with the dispute for years while awaiting compensation. *See id.* at 15.

Doctors also incur high transaction costs in litigation. Even though doctors generally carry malpractice insurance, a lawsuit can keep a doctor away from her practice, where bills are mounting and opportunities are being lost. *See id.* at 16. The emotional cost to doctors in litigation is also very high. Nothing is more humiliating, painful, or embarrassing for a doctor than to be accused of negligently hurting a patient. *See id.* A victory in court probably does little to alleviate this emotional pain. The mere accusation of malpractice can have an adverse effect on a doctor's reputation among her colleagues and her credibility with the community. *See id.*

[10] *See id.* at 15.

[11] *See id.*

by its nature, generally does not allow parties to experience these factors of fairness.[12]

A third factor to consider when measuring the cost of resolving a medical malpractice dispute is the effect the resolution process has on the relationship between the doctor and the patient.[13] Litigation virtually destroys this relationship.[14] Finally, litigation is inherently poor at conclusively resolving issues. Verdicts can be appealed, extending the pain of conflict. Even if there is no appeal, parties to medical malpractice litigation may not believe that the "real" issues have been resolved.[15]

2. *Failure to Deter Negligent Conduct or Improve Quality of Care*

Another criticism of the current system is that tort-based litigation does not effectively deter negligent conduct by physicians.[16] Tort litigation fails in this respect for both theoretical and practical reasons. First, the economic theory of torts simply does not apply to medical malpractice. Learned Hand's famous formula applies best to situations in which negligent conduct is easily identifiable and correctable.[17] However, health care treatment decisions are

---

[12] The factors of fairness are not realized in litigation because litigation is adversarial in nature and inevitably yields a "winner" and a "loser." *See id.* at 16. Litigation is controlled by attorneys, who constantly try to outmaneuver the opposition. *See id.* Additionally, parties to litigation tend not to have as substantial a voice in settlement negotiations as attorneys, whose primary motivation is to put their clients in the best economic position, rather than the best psychological position. Finally, parties to litigation have little or no control over final decisions, which are made by attorneys, juries, or a judge. *See id.*

[13] *See id.*

[14] A doctor considers a malpractice lawsuit to be an attack on her personal character and her professional competency. *See id.* at 18. In addition, a patient would not be filing a lawsuit unless he felt that the doctor had betrayed him. Unfortunately, even if the doctor and the patient have enjoyed a friendly, long-term relationship and actually harbor no ill-will toward one another, litigation forces them to become enemies at war. *See id.* at 16.

[15] For example, a patient who wins a substantial monetary award may not feel vindicated if all he really wanted was for the doctor to look him in the eye and apologize. For further examples, see Sheila M. Johnson, *A Medical Malpractice Litigator Proposes Mediation*, 52 DISP. RESOL. J. 42 (1997).

[16] *See* FURROW ET AL., *supra* note 1, at 336.

[17] The Hand formula finds negligence if the probability of the loss occurring, multiplied by the damages resulting from such a loss, is greater than the cost of preventing the loss [(probability of the loss) x (damage) > (cost of preventing the loss)]. Thus, for example, if the probability of an accident at a railroad crossing is high, and the cost of

far too complex for this simple formula.[18] Another problem with the ability of tort litigation to deter medical negligence is the fact that doctors do not understand tort law. To deter negligent conduct, tort law presumes that doctors understand the legal system and assess negligence using the same standards as juries.[19] This presumption is, however, highly questionable.[20]

Yet another problem is the perception among doctors that the filing of a lawsuit is not necessarily correlated to an incident of malpractice. Doctors tend to believe that malpractice lawsuits are filed arbitrarily and that the best protection against a lawsuit is to be nice to the patients.[21] Some authors have attempted to defend medical malpractice litigation by focusing on the results of certain types of malpractice claims, but these defenses miss the point.[22] The point is that most doctors believe the decision to file a claim in the first place is based on factors other than the claim's merits. This perception prevents litigation from effectively deterring negligent conduct because doctors have

---

erecting a sign that would prevent such an accident is low, then it is negligent not to erect the sign. In this example the negligent conduct is both easily identifiable and correctable. *See* United States v. Carroll Towing Co., 159 F.2d 169, 173 (2d Cir. 1947).

[18] Given the wide range of legitimate treatment decisions for a particular condition, the sheer number of decisions made in the course of treating a patient, and the individuality of each patient, it may be impossible to identify conduct that is "negligent."

[19] *See* Bryan A. Liang, *Medical Malpractice: Do Physicians Have Knowledge of Legal Standards and Assess Cases as Juries Do?*, 3 U. CHI. L. SCH. ROUNDTABLE 68–70 (1996).

[20] Liang found that most of the doctors in his study obtained information on malpractice from the press and that "no physician reported reading the common law on malpractice cases, or even knowing what the common law was." *Id.* at 65; *see also* Johnson, *supra* note 15, at 51 ("[N]othing in medical school . . . prepares physicians for negotiating their way through the legal system. . . . They learn nothing in medical school about law.").

[21] Obviously, such suspicions are difficult, if not impossible, to confirm, but the perception nonetheless exists.

[22] For example, one study concluded that in closed claims for anesthesia-related injuries, 80% of the successful claims based on a theory of substandard care generated compensation for patients. *See* Frederick Cheney et al., *Standard of Care and Anesthesia Liability*, 261 JAMA 1599, 1601 (1989). This study simply does not address the concern that the claims themselves may have been filed arbitrarily. Other studies indicate that juries in medical malpractice cases act fairly, *see, e.g.*, NEIL VIDMAR, MEDICAL MALPRACTICE AND THE AMERICAN JURY: CONFRONTING THE MYTHS ABOUT JURY INCOMPETENCE, DEEP POCKETS, AND OUTRAGEOUS DAMAGE AWARDS 265 (1995), but again these studies only focus on claims that have already been filed.

no confidence that negligent conduct will in fact result in a lawsuit.[23] Further, the current system may cause doctors to engage in the practice of defensive medicine.[24] Far from deterring negligence, defensive medicine may actually expose patients to unnecessary risks.

One final problem with medical malpractice litigation is that it does not encourage patients who have actually suffered injury through medical negligence to bring their claims. Patients are uneducated about their rights and the legal system in general, but even when they do know their rights, they may be discouraged from pursuing medical malpractice claims because the financial and emotional costs are too high. As mentioned above, recent studies have concluded that an incredibly small percentage of patients with meritorious malpractice claims actually file lawsuits.[25] Other studies have concluded that the current litigation system undercompensates patients with minor injuries and overcompensates patients with major injuries.[26]

III. BAD MEDICINE: MISGUIDED ATTEMPTS TO REFORM THE SYSTEM

In an attempt to address the problems of medical malpractice litigation, some states have passed tort reform legislation. Other states have attempted to use alternative dispute resolution. However, none of these reforms adequately addresses the problems with the current tort litigation system. Some commentators have advocated abandoning the current system entirely in favor of new theories of recovery. Although most of these theories have

---

[23] One more important factor that seems to be overlooked in the deterrence issue is the degree to which physician negligence is limited through self-control. It is likely that a doctor's personal remorse and professional embarrassment, not the threat of a lawsuit, is the most effective deterrent of physician negligence.

[24] Defensive medicine occurs when a doctor performs an unnecessary procedure mainly to avoid liability for negligence. Although the actual rate of defensive medicine is difficult to measure, one author estimates that defensive medicine may cost the nation's health care system as much as $15 billion a year. *See* Armand Leone, Jr., *As Health Care Enterprise Liability Expands . . . Is ADR the Rx for Malpractice?*, DISP. RESOL. J., Sept. 1994, at 10. Regardless of the difficulty of measuring the rate of defensive medicine, it can hardly be doubted that legal liability constantly influences doctors' treatment decisions.

[25] *See* DANZON, *supra* note 4, at 10; Localio et al., *supra* note 4, at 248; *see also* LoRea I. Hoycke & Mark M. Hoycke, *Characteristics of Potential Plaintiffs in Malpractice Litigation*, 120 ANNALS OF INTERNAL MED. 792, 796 (1994) (finding from a survey of six law firms in five states that only one out of every thirty calls to the office regarding medical malpractice resulted in the filing of a lawsuit).

[26] *See* WEILER, *supra* note 3, at 53, 54.

merit, this Note argues that such wholesale changes to the current system are both risky and unnecessary.

A. *State Reforms*

1. *Tort Reform Legislation*

Many states have passed tort reform legislation targeted at controlling medical malpractice claims.[27] The problem with tort reform legislation is that the purpose of such legislation is not to increase access to compensation for injured patients or to create a fair dispute resolution system for medical malpractice claims, but rather to decrease the number and size of medical malpractice claims.[28] Typical tort reform legislation decreases the frequency of lawsuits by shortening statutes of limitations, controlling legal fees, and providing for reimbursement to defendants for frivolous claims.[29] Recovery amounts can be limited by mandating periodic payments for long-term sufferers, eliminating the collateral source rule, and capping damage awards.[30] Apparently, states that pass tort reform legislation believe that a ninety percent rate of denial of compensation to injured patients is too low.

2. *Arbitration and "Mediation"*

Many commentators have advocated the use of alternative dispute resolution to resolve medical malpractice disputes.[31] Some states have actually instituted programs that purportedly use ADR to resolve medical malpractice disputes. Unfortunately, all of these attempts have suffered from either poor conception or poor execution. For example, in California the managed care

---

[27] *See* FURROW ET AL., *supra* note 1, at 317–319.

[28] Tort reform legislation is typically supported by insurance companies, which believe that tighter controls on medical malpractice claims will improve the malpractice liability insurance market. *See id.*

[29] *See id.*

[30] *See id.*

[31] *See, e.g.*, Patricia I. Carter, *Binding Arbitration in Malpractice Disputes: The Right Prescription for HMO Patients?*, 18 HAMLINE J. PUB. L. & POL'Y 423, 424 (1997); Johnson, *supra* note 15, at 43; Leone, *supra* note 24, at 10–12; Reeves, *supra* note 7, at 16–20; Carl M. Stevens, *The Benefits of ADR for Medical Malpractice: Adopting Contract Rather than Tort Cases*, DISP. RESOL. J., Apr./June 1995, at 65, 65.

giant Kaiser Permanente instituted a system of mandatory, binding arbitration for patients who filed malpractice claims.[32] However, the system was so adversarial and biased in favor of Kaiser that a California court called the system "unconscionable."[33]

Other states have attempted to use mediation to resolve medical malpractice disputes. However, none of the mediation programs instituted by these states resembles "mediation" as practiced by ADR professionals, and generally these attempts have met little success.[34] A legitimate attempt would probably encompass the following four main principles of mediation: self-determination, impartiality, fairness, and confidentiality.[35] Unfortunately, current attempts at mediation do not appear to pursue these principles. As a result of these poor attempts at mediation, many legal practitioners believe that mediation of medical malpractice disputes simply does not work.[36]

B. *New Theories of Recovery*

In an attempt to address the problems of medical malpractice litigation, some commentators have suggested new theories of recovery, such as no-fault liability, enterprise liability, and contract law. Although most of these ideas have merit, each would necessitate wholesale changes to the current system, and the actual impact of these theories would be difficult to predict.

---

[32] *See* Carter, *supra* note 31, at 427.

[33] *Id.* at 435 (citing Engalla v. Permanente Med. Group, 43 Cal. Rptr. 2d 621, 624 (Cal. Ct. App. 1995)).

[34] *See, e.g.*, Jessica Fonseca-Nader, *Florida's Comprehensive Medical Malpractice Reform Act: Is It Time for a Change?*, 8 ST. THOMAS L. REV. 551, 556 (1996) (describing Florida's program); Johnson, *supra* note 15, at 45 (describing Michigan's and Wisconsin's programs). Michigan's program, for example, involves the evaluation of a malpractice claim by a panel of five people, none of whom have formal training in mediation. The parties do not even attend the evaluation session. The panel recommends a settlement award, which can be rejected by either party. If the award is rejected, the rejecting party must improve his position at trial by at least 10% or he will be sanctioned. *See* Johnson, *supra* note 15, at 45, 46. Michigan's "mediation" panel is typical of those in other states, which also bear few characteristics of proper mediation. *See, e.g.*, Fonseca-Nader, *supra*, at 557; Johnson, *supra* note 15, at 46.

[35] See Johnson, *supra* note 15, at 50–51 for a more thorough discussion of these principles in the context of medical malpractice disputes.

[36] *See id.* at 46.

1. *No-Fault Liability*

One theory that is popularly suggested as an alternative to traditional tort liability is no-fault liability.[37] A no-fault system eliminates negligence as a condition of compensation for injury. Proponents of a no-fault system for medical injury assert that such a system would compensate far more patients who are injured by a doctor's negligence than the current tort system—and at much lower cost.[38] However, because negligence is not a factor in a no-fault system, such a system also compensates patients who are not the victims of medical negligence. Thus, a no-fault system does not act as a deterrent of negligent conduct.[39] Another concern about a no-fault system for medical injury is that the cost of compensating such a larger pool of claimants would render such a system cost prohibitive.[40]

Perhaps most importantly, precious little empirical information exists that could help predict the societal impact of a complete transition from tort liability to no-fault liability.[41] Some authors have studied no-fault systems that are extremely limited in scope,[42] while other authors have examined broad no-fault systems in other countries.[43] However useful such studies may be, they

---

[37] *See generally* Randall R. Bovbjerg et al., *Administrative Performance of "No-Fault" Compensation for Medical Injury*, LAW & CONTEMP. PROBS., Spring 1997, at 71; Frank A. Sloan et al., *The Road from Medical Injury to Claims Resolution: How No-Fault and Tort Differ*, LAW & CONTEMP. PROBS., Spring 1997, at 35; David M. Studdert et al., *Can the United States Afford a "No-Fault" System of Compensation for Medical Injury?*, LAW & CONTEMP. PROBS., Spring 1997, at 1.

[38] *See* Studdert et al., *supra* note 37, at 3.

[39] In the area of automobile accident liability, where no-fault has been adopted by some states, the evidence suggests that no-fault actually increases the rate of automobile fatalities. *See* Frank A. Sloan, *Automobile Accidents, Insurance, and Tort Liability*, *in* 1 THE NEW PALGRAVE DICTIONARY OF ECONOMICS AND THE LAW 140, 142–143 (Peter Newman ed., 1998).

[40] *See* Studdert et al., *supra* note 37, at 2.

[41] *See* Jerry L. Mashaw & Theodore R. Marmor, *Conceptualizing, Estimating, and Reforming Fraud, Waste, and Abuse in Healthcare Spending*, 11 YALE J. ON REG. 455, 487 (1994) (commenting that "[t]here are currently no good cost estimates for this sort of major malpractice reform").

[42] *See* Bovbjerg et al., *supra* note 37, at 73.

[43] *See* Studdert et al., *supra* note 37, at 3.

simply cannot accurately predict the effect of a nationwide switch to no-fault liability for medical malpractice disputes.[44]

2. *Enterprise Liability*

Another theory suggested as a remedy to the current system is the theory of enterprise liability. To understand this theory, a brief description of managed care is helpful. Managed care describes a system of health care delivery in which a patient's health care is coordinated by a group of providers to optimize cost efficiency.[45] Managed care is important because it has become a significant force in modern health care delivery,[46] and because it profoundly affects health care itself. Although many forms of managed care exist, each is alike in that it prevents doctors from exercising unfettered discretion over the health care decisions for a patient.[47]

Under the theory of enterprise liability, medical malpractice liability shifts from the individual doctor to the managed care organization.[48] This shift, in effect, immunizes individual doctors from malpractice lawsuits because patients file claims against the managed care organization rather than against individual doctors.[49] At first blush, the potential benefits of enterprise liability

---

[44] For example, how can one measure the certain resistance to such a shift in the status quo by the courts and the bars? Admirably, one set of authors admits to the limited utility of their study by stating that "the precise findings of this data-based study of two small programs seem unlikely to be precisely replicated." Bovbjerg et al., *supra* note 37, at 106.

[45] Managed care systems developed as a market-driven response to rapidly increasing health care costs. *See* Tracy E. Miller, *Managed Care Regulation: In the Laboratory of the States*, 278 JAMA 1102, 1102 (1997). Managed care cuts costs by providing financial incentives to limit treatment and by relying on primary care doctors as "gatekeepers" for specialty services. *See* Eve A. Kerr et al., *Primary Care Physicians' Satisfaction with Quality of Care in California Capitated Medical Groups*, 278 JAMA 308, 308 (1997).

[46] According to one recent study, nearly 80% of the primary care physicians in the United States have at least one managed care contract, and approximately 42% are employees of some managed care organization. *See* Phillip R. Kletke et al., *Current Trends in Physicians' Practice Arrangements: From Owners to Employees*, 276 JAMA 555 (1996).

[47] Common managed care organizations include the health maintenance organization (HMO), the independent practice association (IPA), and the preferred provider organization (PPO). These integrated delivery systems act as both insurers and providers at the same time. *See* FURROW ET AL., *supra* note 1, at 284.

[48] *See* Leone, *supra* note 24, at 7.

[49] *See id.*

are apparent. By consolidating liability into a single entity, the ability to predict claims and losses and price malpractice insurance could improve, doctors could avoid the emotional stress of a personal lawsuit, managed care organizations would have an incentive to institute quality control measures, and plaintiffs' trial costs could be lower.[50]

Although enterprise liability offers substantial possible benefits, it also suffers from both theoretical and practical problems. First, because enterprise liability retains traditional tort theory as a basis of recovery, it also retains the problems associated with tort theory. Namely, if tort litigation is generally an ineffective method of deterring physician negligence or improving health care quality, why should substituting one defendant for another make a difference? Second, attempts to impose enterprise liability on managed care organizations typically run head-first into the Employee Retirement Income Security Act of 1974.[51] Thus, even if enterprise liability theoretically could alleviate the problems of medical malpractice litigation, effective implementation of such a system would require massive reform of existing laws.[52]

3. *Contract Law*

Yet another group of commentators has advocated a switch from tort law altogether to contract law. Traditionally, malpractice claims have been resolved under tort law, even though an implied contract exists in the doctor-patient relationship.[53] Today, most doctor-patient relationships exist within the context of a managed care plan, in which an explicit contract stipulates a range of health services to be provided at a specific cost.[54] The existence of an explicit contract establishes, obviously, an incentive to resolve malpractice

---

[50] *See* Sage, *supra* note 2, at 166.

[51] *See id.* at 180. The Employee Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829 (codified as amended in scattered sections of 26 U.S.C., 29 U.S.C. §§ 1001–1461), preempts many personal injury claims brought against employers, including claims brought against entities that act at the direction of employers, such as employer-provided health insurance organizations. Preemption means that plaintiffs must bring suits in federal court, where the right to a jury trial may not be guaranteed and the maximum potential recovery may be much lower than in state court. *See* Sage, *supra* note 2, at 180.

[52] Indeed, Sage finally concludes that the only way to effectively implement enterprise liability is through comprehensive, national health reform legislation. *See id.* at 206.

[53] *See* Stevens, *supra* note 31, at 66; *see also* Carter, *supra* note 31, at 426.

[54] *See* Stevens, *supra* note 31, at 66.

disputes under contract law. Advocates of the use of contract law to resolve medical malpractice disputes assert that such a system would clarify the duties of health care providers and foster development of efficient methods to resolve health care disputes.[55] However, the use of contract law to resolve medical malpractice disputes raises many potential problems.[56]

First, how would contract law handle the issue of nonpaying patients, such as infants or indigents?[57] That is, could a health care "contract" exist in the absence of consideration by one party? Also, the very nature of medical malpractice—unforeseen incidents—is precisely what contract law is ill equipped to handle.[58] Next, contract law works best when the parties have equal bargaining power, a factor that is anything but assured in a health care contract.[59] Finally, there is little evidence that switching to contract law would itself alleviate the problems of medical malpractice litigation.[60]

Other theories of recovery have been advocated, such as the use of a tort-based implied warranty of quality for managed care organizations,[61] but such theories generate the same potential problems as the ones described above. Such reforms involve major changes to the existing system, and little empirical evidence exists suggesting that the reforms could alleviate the problems currently facing the system.

---

[55] For example, rather than relying on Learned Hand's negligence equation, managed care members and organizations could negotiate particular terms into the health care contract as a means of spreading the costs of accident prevention. *See id.*

[56] One potential problem with the use of contract theory, of course, is that injured patients might be limited to expectancy damages, rather than the plaintiff-friendly damage limits of tort law.

[57] *See* P.S. Atiyah, *Medical Malpractice and the Contract/Tort Boundary*, LAW & CONTEMP. PROBS., Spring 1996, at 287, 293.

[58] *See id.* at 294.

[59] Indeed, the most frequent consumers of medical care are typically the weakest members of society. *See id.* at 295.

[60] That is, the health care contract would probably simply specify the tort standard of reasonable care as the standard for determining whether a contract breach had occurred. *See id.* at 299.

[61] *See* William S. Brewbaker III, *Medical Malpractice and Managed Care Organizations: The Implied Warranty of Quality*, LAW & CONTEMP. PROBS., Spring 1997, at 117, 118.

IV. MEDIATION IN THEORY

Despite the ill-conceived attempts at the use of ADR to resolve medical malpractice disputes, mediation still holds great promise as a method of resolving these disputes. Mediation is a facilitated negotiation in which parties discuss their dispute with the help of a neutral third party, whose role is to help the parties communicate with one another.[62] A mediator has no authority to impose a resolution; he is primarily concerned with guiding the parties to a voluntary and mutually acceptable settlement.[63] The theoretical arguments in favor of the use of mediation to resolve medical malpractice disputes are discussed below.

A. *The Benefits of Mediation in General*

As a general matter, mediation has several advantages over litigation. First, the costs associated with mediation generally are lower than those with litigation. Disputes are typically resolved much faster in mediation than in litigation, and thus attorneys' fees and other out-of-pocket expenses are reduced.[64] Mediation, with its emphasis on cooperation and conciliation, also does not exact as harsh an emotional toll on the parties as does litigation.

A second way in which mediation outperforms litigation relates to the overall satisfaction of the parties with the resolution process. Satisfaction depends on the parties' sense of fairness, which in turn is determined by the opportunity to express oneself, participation in shaping a settlement, and control over final decisions.[65] Mediation, by its nature, allows parties to express themselves, to contribute significantly to any settlement agreement, and to have ultimate control over final decisions.[66]

---

[62] *See* KIMBERLEE K. KOVACH, MEDIATION PRINCIPLES AND PRACTICE 16–17 (1994).

[63] *See id.*; *see also* CHRISTOPHER W. MOORE, THE MEDIATION PROCESS: PRACTICAL STRATEGIES FOR RESOLVING DISPUTES 15 (1986).

[64] *See, e.g.*, William A. Quinby, *Why Health Care Parties Should Mediate Rather than Litigate*, HEALTHSPAN, Jan. 1994, at 13.

[65] *See* Reeves, *supra* note 7, at 15.

[66] Although litigation does not entirely prohibit these factors of fairness, there is little doubt that mediation outperforms litigation in its ability to promote these factors.

B. *The Benefits of Mediation Within the Context of the Doctor-Patient Relationship*

To appreciate mediation's utility in the area of medical malpractice, it is helpful to discuss the importance of the doctor-patient relationship. For many people, the doctor-patient relationship is as highly personal as relationships with family or clergy. Also, most patients experience emotional suffering in addition to their physical ailment when they visit a doctor. A patient worries about the outcome of his treatment, the possibility of discomfort, the impact of the situation on his family, and the cost of treatment.[67] Patients, who generally have little or no understanding of medicine, often give doctors significant control over treatment decisions. This relinquishment of control places doctors in positions of extreme trust.

In contrast, doctors know that medicine is often more like an art than a science and that nothing is absolute. They know that even when the highest standard of care is given, mistakes or unexpected results may occur.[68] Additionally, doctors have to consider issues beyond merely the patient's needs, such as billing, insurance, and relationships with other doctors.[69]

Patients tend to approach the doctor-patient relationship subjectively, but doctors tend to approach the relationship objectively. A patient has a physical illness and anxieties; a doctor has the scientific method. This dichotomy can lead to problems with communication.[70] Patients can feel threatened, confused, or abandoned by doctors who do not communicate clearly.[71] Patients may also misinterpret a doctor's businesslike demeanor as a lack of caring.[72] Doctors, who sincerely believe that they make the best treatment decisions for their patients, do not want to burden patients with complicated terminology and consequently may contribute to the communication problem by not disclosing enough information.[73] When communication is poor,

---

[67] *See* Ann J. Kellet, *Healing Angry Wounds: The Roles of Apology and Mediation in Disputes Between Physicians and Patients*, 1987 J. DISP. RESOL. 111, 114.

[68] *See* Reeves, *supra* note 7, at 14.

[69] *See id.*

[70] *See id.* at 15.

[71] *See* Kellet, *supra* note 67, at 123.

[72] *See id.* at 121.

[73] *See id.* at 118.

mistrust increases, and patients search for problems where none may actually exist.[74]

Mediation would outperform litigation in its ability to maintain the doctor-patient relationship.[75] Although medical negligence will likely sever the doctor-patient relationship no matter how the dispute is resolved, mediation at least gives that relationship some chance to continue.[76] This is important because managed care organizations are extremely interested in maintaining doctor-patient relationships. Managed care organizations that contract with large employers, for example, risk losing many members if patients are unhappy with their doctors.[77]

Mediation also outperforms litigation in its ability to resolve the "real" issues. Litigation tends to focus on monetary liability and blame. However, the potential damage award amount is often not of paramount concern for an injured patient.[78] Hardened litigators may forget that many disputes can be resolved by simply having the parties talk to each other. Because mediation allows the parties to express their feelings openly, the doctor and the patient are more likely to feel that the real issues have been resolved.[79]

C. *Potential Problems of Mediation*

Although many commentators have advocated the use of mediation to resolve medical malpractice disputes, few case studies have been undertaken to measure or predict mediation's effectiveness in this area. Thus, very little

---

[74] *See id.* at 122.

[75] "Mediation is an appropriate process where the parties wish to preserve an on-going relationship or to terminate an existing relationship in the least adversarial way." 5A OHIO JUR. 3D *Alternative Dispute Resolution* § 11 (1997).

[76] *See* Carter, *supra* note 31, at 445.

[77] Managed care organizations try to maintain relationships with members, even when there is a dispute between a member and an individual physician. *See* Leone, *supra* note 24, at 10.

[78] In a typical medical malpractice dispute, an injured patient feels confused and betrayed and may simply want the doctor to explain why something went wrong or to apologize. *See* Catherine S. Meschievitz, *Mediation and Medical Malpractice: Problems with Definition and Implementation*, LAW & CONTEMP. PROBS., Winter 1991, at 200.

[79] Sheila Johnson relates the following story about a client (an injured patient): "My client has repeatedly said to me, 'I just want to ask [the doctor] why she treated me that way.' . . . I also got the impression . . . that [the doctor] also wants to explain her actions very much." Johnson, *supra* note 15, at 49.

empirical evidence exists regarding the effectiveness of mediation as a method of resolving medical malpractice disputes. Part of the problem is that due to the failed attempts at the use of mediation described above, lawyers hold many misconceptions about mediation's effectiveness. Among the common misconceptions are the following: (1) patients are not compensated as generously in mediation as they are in litigation, (2) patients will be intimidated into prematurely settling meritorious claims during mediation, and (3) mediation simply prolongs the dispute process by delaying the real resolution process—litigation. The goal of the next part of this Note is to dispel some of the misconceptions about mediation by examining actual case studies of the use of mediation.

V. MEDIATION IN PRACTICE

At least two case studies have recently been conducted which strongly suggest that mediation actually can alleviate many of the problems associated with the medical malpractice litigation system. The first study was conducted by Douglas Henderson, a construction law practitioner, who examined the effectiveness of mediation in over five hundred construction disputes.[80] The second study, conducted by two professors of economics—Henry S. Farber and Michelle J. White—evaluated several hundred medical malpractice cases brought at a hospital that provides a voluntary, informal dispute resolution procedure.[81]

A. *The Henderson Study*

Although the Henderson study examined mediation in the context of construction disputes, the goal of the Henderson study was to develop answers to several common questions regarding the effectiveness of mediation in general by examining the "determinants of mediation success across a wide range of dispute fact patterns, case situations, and mediator abilities and

---

[80] *See generally* Douglas A. Henderson, *Mediation Success: An Empirical Analysis*, 11 OHIO ST. J. ON DISP. RESOL. 105 (1996). The disputes examined in the Henderson study ranged in amount in controversy from $600 to $100 million, and in number of parties from 2 to 70. *See id.* at 141. Most disputes involved more than two issues. *See id.* Mediations that ended in full settlement were considered successful. *See id.* at 136–137.

[81] *See generally* Henry S. Farber & Michelle J. White, *A Comparison of Formal and Informal Dispute Resolution in Medical Malpractice*, 23 J. LEGAL STUD. 777 (1994).

innovations."[82] Henderson's conclusions are extremely interesting. For example, Henderson concludes that relatively few factors have a strong impact on the final outcome of mediation. The factors that do have a strong impact all relate to the mediation process itself, as opposed to mediator skills or the substantive nature of the dispute.[83]

Henderson's results are important because they dispel many misconceptions about mediation. First, Henderson found that successful mediation takes time. Specifically, the mediations that lasted two or more days were ninety-five percent more likely to settle than the ones that did not last that long.[84] Second, Henderson found that the type of dispute, the number of issues, and the number of parties each had no discernible effect on mediation outcome.[85] Third, although no one specific tactic used by the mediator was related to mediation success, *diversity* of tactics was very important. That is, when a mediator uses two or more specific mediation tactics, settlement is nearly twice as likely to occur.[86] Fourth, very interestingly, "the source of mediation rules used . . . was, by far, the best predictor of mediation settlement."[87] Specifically, settlement was much more likely to occur if the parties developed their own mediation rules, as opposed to using rules developed by an institution such as the American Arbitration Association or the Center for Public Resources.[88] Fifth, settlement was much more likely if some discovery (not necessarily full discovery) occurred before mediation.[89] Finally, whether mediation was forced or voluntary had no significant impact on mediation outcome.[90]

The Henderson study is relevant, then, because it demonstrates that mediation can effectively resolve disputes involving large amounts in controversy, multiple parties, and multiple issues. As is the case with construction industry disputes, medical malpractice disputes often involve

---

[82] Henderson, *supra* note 80, at 106. The study examined whether the following factors affected mediation success: amount in controversy, number of issues, number of parties, theory of the case (i.e., tort versus contract), mediator skill, and mediator tactics.

[83] *See id.* at 107.

[84] *See id.* at 143.

[85] *See id.* at 144.

[86] *See id.*

[87] *Id.* at 145.

[88] *See id.*

[89] *See id.* at 145–146.

[90] *See id.* at 146.

large amounts in controversy, multiple parties, and multiple issues. Although comparisons between construction disputes and medical malpractice should be made cautiously,[91] the results of the Henderson study have obvious implications in the area of medical malpractice. However, even stronger proof of the utility of ADR to resolve medical malpractice disputes can be found in the Farber and White study, discussed below.

B. *The Farber and White Study*

Farber and White examined several hundred medical malpractice cases involving a hospital that offered a voluntary, informal complaints process to patients.[92] The study compared the experiences of patients who began the dispute resolution process in two different manners: those who filed a lawsuit and those who began the process by filing a complaint with the hospital's informal dispute resolution office. The goal of the study was to determine whether lawsuit-based disputes differed from complaint-based disputes in terms of the following: how the case was resolved, settlement amount, and quality of care (based on assessments by the hospital's experts).[93]

The results of the Farber and White study suggest that ADR can be an effective tool to resolve medical malpractice disputes fairly. For example, the complaint process costs the hospital about $200 on average, as compared with $31,000 to defend a lawsuit that was tried to a verdict.[94] Also, about half of the complaint-based disputes were resolved without the filing of a lawsuit.[95] Of the 465 cases that either began as or became lawsuits, only 26 were tried to a verdict. Of these, plaintiffs won only four cases. Interestingly, three of

---

[91] For example, the relative bargaining strengths and knowledge of issues between parties to a construction dispute may be quite different than those between parties to a medical malpractice dispute.

[92] The alternative dispute resolution system offered by the hospital in the Farber and White study is even less formal than mediation. No lawyers are involved; rather, plaintiffs represent themselves, and the hospital is represented by an in-house complaints staff. The process is actually a prelitigation measure designed to encourage early settlement of disputes before lawsuits are even filed. *See* Farber & White, *supra* note 81, at 779.

[93] *See id.* at 787. Patients who utilized the informal complaint process were at all times free to file a lawsuit. *See id.* at 785.

[94] *See id.* at 778. Additionally, the average cost to the hospital to defend a lawsuit that settled was $14,000, and the cost to defend a lawsuit that was dropped was $7000! *See id.*

[95] *See id.* at 788.

the four lawsuits won by plaintiffs began as informal complaints.[96] Although only fifteen percent of the cases tried to a verdict were won by plaintiffs, the hospital's experts determined that about forty-two percent of the cases tried to a verdict involved poor quality care.[97] Farber and White also determined that the manner by which a case was resolved (that is, whether it was dropped, settled, or tried to a verdict) did not depend on whether the case began as a complaint or a lawsuit.[98] However, settlement amounts at the complaint stage were about one-third as much as settlement amounts at the lawsuit stage.[99]

Farber and White concluded that the informal complaint process was a cost-effective way to facilitate the flow of information between the hospital and the patients.[100] Further, the authors speculated that if the hospital's informal complaint process were mandatory, the total savings in legal costs for both the hospital and patients would exceed five million dollars annually.[101]

VI. CONCLUSION

It is almost universally agreed that the current tort-based litigation system is an ineffective method of resolving medical malpractice disputes. Tort-based litigation fails to compensate injured patients, to deter physician negligence, or to provide a dispute resolution system that is fair to all parties. However, the purpose of most reforms instituted by states has been to further decrease injured patients' access to the legal system. In an attempt to devise a system that compensates injured patients, deters physician negligence, and is fair, some commentators have advocated wholesale changes to medical malpractice

---

[96] *See id.* at 802. In addition, the fourth case won by a plaintiff began as a hospital incident report, not as a patient-initiated lawsuit. *See id.*

[97] Thus, litigation did not effectively compensate patients injured through medical negligence.

[98] *See id.* at 797.

[99] *See id.* at 799. This result carries two important caveats. First, lawsuit settlement amounts did not depend on whether the cases originated as lawsuits or complaints. Second, the lower settlement amounts at the complaint stage may actually have put more money in the patients' hands, considering the amount of money the patients saved by not going to trial.

[100] *See id.* at 806. That is, the hospital and the patients received the same type of information about each other that they would have in litigation but at much lower cost. *See id.*

[101] *See id.* at 804.

recovery theory. Unfortunately, it is difficult to predict whether these changes could actually alleviate the problems of the current system, and it is unlikely that such fundamental shifts in legal theory would be easily instituted. Finally, some states have attempted to use alternative dispute resolution, but most of these attempts have been disastrously conceived and executed.

The best solution to the problems of the current medical malpractice system is to institute a program similar to the one used by the hospital in the Farber and White study. That is, the system should provide mediation ("true" mediation) as a first step in the malpractice dispute process. This simple step would increase compensation to injured patients because patients would cheaply and quickly gain access to the legal system. Yet, hospitals would dispose of claims much faster and at much lower cost. Moreover, this system would improve quality of care because mediation encourages the flow of information between doctors and patients.[102] The system would also be more fair than the current one because the parties would have a chance to arrive at a mutually satisfactory resolution before advancing to an adversarial lawsuit.

The use of mediation as a first step in the medical malpractice dispute process would also be very easy to implement. First, the cost of running a mediation program is relatively low. Second, the legal community would be much more likely to accept a reform that does not involve wholesale changes in the theory of recovery. Finally, alternative dispute resolution is enjoying ever-increasing popularity, especially in the area of health care. For example, every health care reform bill that has recently come before Congress has included some provision encouraging the use of ADR to resolve health care disputes.[103] In addition, in August 1998, a Commission on Health Care Dispute Resolution, comprised of the American Arbitration Association, American Bar Association, and American Medical Association, established ground rules for the use of ADR to resolve health care disputes in the managed care environment.[104] Thus, it appears that the time is ripe to add a spoonful of mediation to the medical malpractice dispute process.

---

[102] Doctors, therefore, could gain insights they might otherwise not.

[103] *See generally* William T. D'Zurilla, *Federal Health Care Bills Include ADR*, 41 LA. B.J. 560 (1994).

[104] *See Rules for Dispute Resolution*, AM. MED. NEWS, Sept. 7, 1998, at 30.